



General Assembly

Substitute Bill No. 108

February Session, 2004

* SB00108INS__030304__ *

**AN ACT CONCERNING APPEALS OF HEALTH CARE
DETERMINATIONS MADE TO THE INSURANCE COMMISSIONER.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-478n of the general statutes, as amended by
2 section 94 of public act 03-278, is repealed and the following is
3 substituted in lieu thereof (*Effective October 1, 2004*):

4 (a) [On or after January 1, 1998, any] Any enrollee, or any provider
5 acting on behalf of an enrollee with the enrollee's consent, who has
6 exhausted the internal mechanisms provided by a managed care
7 organization or utilization review company to appeal [a] the denial of
8 a claim based on medical necessity or a determination not to certify an
9 admission, service, procedure or extension of stay, regardless of
10 whether such determination was made before, during or after the
11 admission, service, procedure or extension of stay, may appeal such
12 denial or determination to the commissioner.

13 (b) (1) To appeal a [decision under the provisions of] denial or
14 determination pursuant to this section [,] an enrollee or any provider
15 acting on behalf of an enrollee shall, [within] not later than thirty days
16 [from] after receiving [a] final written notice of the denial or
17 determination from the enrollee's managed care organization or
18 utilization review company, file a written request with the

19 commissioner. The appeal shall be on forms prescribed by [said] the
20 commissioner and shall include the filing fee [provided for] set forth in
21 subdivision (2) of this [section] subsection and a general release
22 executed by the enrollee for all medical records pertinent to the appeal.
23 The managed care organization or utilization review company named
24 in the appeal shall also pay to the commissioner the filing fee set forth
25 in subdivision (2) of this subsection.

26 (2) The filing fee shall be twenty-five dollars and shall be deposited
27 [into] in the Insurance Fund established in section 38a-52a. If the
28 commissioner finds that an enrollee is indigent or unable to pay the
29 fee, the commissioner shall waive the enrollee's fee. Upon completion
30 of the medical review pursuant to this section, the commissioner shall
31 refund to the prevailing party any filing fee paid by the prevailing
32 party.

33 (3) Upon receipt of the appeal together with the executed release
34 and appropriate fee, the commissioner shall assign the appeal for
35 review to an entity as defined in subsection (c) of this section.

36 (4) Upon receipt of the request for appeal from the commissioner,
37 the entity conducting the appeal shall conduct a preliminary review of
38 the appeal and accept [it] the appeal if such entity determines: (A) The
39 individual was or is an enrollee of the managed care organization; (B)
40 the benefit or service that is the subject of the complaint or appeal
41 reasonably appears to be a covered service, benefit or service under the
42 agreement provided by contract to the enrollee; (C) the enrollee has
43 exhausted all internal appeal mechanisms provided; (D) the enrollee
44 has provided all information required by the commissioner to make a
45 preliminary determination including the appeal form, a copy of the
46 final decision of denial and a fully-executed release to obtain any
47 necessary medical records from the managed care organization and
48 any other relevant provider.

49 (5) Upon completion of the preliminary review, the entity
50 conducting such review shall immediately notify the member or

51 provider, as applicable, in writing as to whether the appeal has been
52 accepted for full review and, if not so accepted, the reasons [therefore]
53 why the appeal was not accepted for full review.

54 (6) If accepted for full review, the entity shall conduct such review
55 in accordance with the regulations adopted by the commissioner, after
56 consultation with the Commissioner of Public Health, in accordance
57 with the provisions of chapter 54.

58 (c) To provide for such appeal the Insurance Commissioner, after
59 consultation with the Commissioner of Public Health, shall engage
60 impartial health entities to provide for medical review under the
61 provisions of this section. Such review entities shall include (1) medical
62 peer review organizations, (2) independent utilization review
63 companies, provided any such organizations or companies are not
64 related to or associated with any managed care organization and (3)
65 nationally recognized health experts or institutions approved by the
66 commissioner.

67 (d) (1) Not later than five business days after receiving a written
68 request for any information set forth in this subdivision a managed
69 care organization whose enrollee is the subject of an appeal shall
70 provide to the enrollee, the enrollee's designee or the commissioner:
71 (A) A copy of the entire policy or contract between the enrollee and the
72 managed care organization, and (B) written verification of whether the
73 enrollee's managed care plan is fully insured, self-funded, or otherwise
74 funded.

75 (2) Failure of the managed care organization to provide a copy of
76 the entire policy or contract within said five-day period or before the
77 expiration of the thirty-day period for appeals set forth in subdivision
78 (1) of subsection (b) of this section, whichever is later as determined by
79 the commissioner, shall (A) create a presumption on the review entity,
80 for purposes of accepting an appeal pursuant to subdivision (4) of
81 subsection (b) of this section, that the benefit or service that is the
82 subject of the appeal is a covered benefit under the applicable policy or

83 contract and (B) entitle the Insurance Commissioner to require the
 84 managed care organization to reimburse the department for the
 85 expenses related to the appeal, including, but not limited to, expenses
 86 incurred by the review entity.

87 [(d)] (e) The commissioner shall accept the decision of the
 88 [reviewing] review entity and the decision of the commissioner shall
 89 be binding.

90 [(e)] (f) Not later than January 1, 2000, the Insurance Commissioner
 91 shall develop a comprehensive public education outreach program to
 92 educate health insurance consumers of the existence of the appeals
 93 procedure established in this section. The program shall maximize
 94 public information concerning the appeals procedure and shall
 95 include, but not be limited to: (1) The dissemination of information
 96 through mass media, interactive approaches and written materials; (2)
 97 involvement of community-based organizations in developing
 98 messages and in devising and implementing education strategies; and
 99 (3) periodic evaluations of the effectiveness of educational efforts. The
 100 Managed Care Ombudsman shall coordinate the outreach program
 101 and oversee the education process.

This act shall take effect as follows:	
Section 1	October 1, 2004

INS *Joint Favorable Subst.*